State Variance Approval for HFS 133.20(3) Review of Plan and Implementation of Medicare Prospective Payment System

Date: August 21, 2000 **DSL-BQA-00-063**
To: Home Health Agencies **HHA 24**
From: Jan Eakins, Chief, Provider Regulation and Quality Improvement Section
Via: Sue Schroeder, Director, Bureau of Quality Assurance

The purpose of this memorandum is to provide you with information related to Wisconsin Administrative Code, HFS 133.20(3), Review of Plan, and the relationship of this state rule to the implementation of the federal Medicare Prospective Payment System (PPS).

Review of Plan

Effective October 1, 2000, the Bureau of Quality Assurance (BQA) will *rescind* the January 17, 1990 memorandum # 90-007 that allowed a variance to Wisconsin Administrative Code HFS 133.20(3), Review of Plan. This variance allowed home health agencies to have a maximum of 62 days to review the plan of treatment/plan of care. As of October 1, 2000, the attending physician and agency staff must review the plan of care at least every 60 days or as often as the severity of the patient's condition requires. The 60-day plan of care review will be applicable to *all patients* (Medicare, Medicaid, and Private Pay) served by a licensed only and/or licensed and Medicare certified home health agency.

This change will conform with the federal Health Care Financing Administration (HCFA) amendment to the home health regulations at 42 CFR 484.18(b) that changes the timing of plan of care reviews from 62 to 60 days effective October 1, 2000. The specific federal language is noted in the July 3, 2000, federal PPS final rule, page 41211.

One Time Variance

Effective immediately, BQA will also grant a one-time variance to the 60-day plan of care review timeline at HFS 133.20(3).

This variance is being granted to be in concert with the federal Health Care Financing Administration one time grace period for the plan of care recertification period (90 days rather than 62 days) to facilitate the transition of all Medicare skilled patients to the prospective payment system (PPS) effective October 1, 2000.
With the implementation of PPS, all Medicare skilled patients on service at the home health agency prior to September 1, 2000, are required to have an OASIS routine follow-up assessment (OASIS B-1 8/2000,) conducted in September.

For Medicare patients only, due for follow-up recertification in August, the home health agency can obtain a verbal order to extend the existing plan of care into September. The OASIS assessment would also be delayed until September. All plans of care for the Medicare PPS patients developed during September will be allowed to span a maximum of 90 days. All plans of care within the grace period must have an end date no later than November 29, 2000.

Medicare skilled patients admitted during September will require a start of care (SOC) assessment. The initial plan of care for each Medicare PPS patient would cover the SOC date and end no later than November 29, 2000. Follow-up assessments and plan of care reviews, subsequent to November 29, 2000, would cover each additional 60-day period until discharge.

BQA finds that granting this variance will not jeopardize the health, safety or welfare of home health patients.

Compliance Issues

During the transition to PPS, BQA home health surveyors will not be citing 42 CFR 484.18(b) and HFS 133.20(3) deficiencies related to the 60-day timeline for Medicare Prospective Payment patients only. Private pay and Medicaid only patients are *excluded* from the one time HFS 133.20(3) variance. *This one-time state variance and*

federal grace period does not preclude the home health agency from meeting federal and state requirements to have physician orders for the provision of services.

Compliance with the 60-day timeline for plan of care reviews for Medicare PPS patients will resume after November 29, 2000.

Additional Resources

Attached is a document entitled OASIS Considerations for Medicare Patients that contains additional guidance regarding PPS and OASIS.
Questions related to the plan of care reviews and applicability to OASIS can be directed to Barbara Woodford, Home Health Nurse Consultant at woodfba@dhfs.state.wi.us or (715) 855-7310.

Questions related to survey protocols can be directed to Jane Walters, Health Services Section Northern Unit Supervisor at walteja@dhfs.state.wi.us or (608) 267-7389 and Juan Flores, Health Services Section Southern Unit Supervisor at florejj@dhfs.state.wi.us or (608) 261-7824.

OASIS CONSIDERATIONS FOR MEDICARE PPS PATIENTS

Type of Episode or Adjustment	OASIS Assessment: M0100 & M0825* Response Selection	Comments
1. PPS Start-up	**Medicare fee-for-service (FFS) patients on service prior to October 1**: For existing Medicare FFS (M0150=1) patients expected to have a continued need for service extending past October 1, HHAs **must** complete a follow-up (or SOC if patient is admitted during September) OASIS assessment using the new OASIS B-1 (8/2000) data set and encode it using the HAVEN 4.0 software (or other HAVEN-like vendor software) any time during the month of September. Follow-ups due in August may be delayed to September. The first certification period under PPS may span up to 90 days. This is a one-time only deviation (grace period) from the required time points for OASIS collection and reporting. **Follow-up assessments for all Medicare FFS (M0150=1) beneficiaries:** For beneficiaries with a continued need for services, a follow-up assessment using OASIS B-1 (8/2000) must be completed during the last 5 days of the first HHPPS start-up period, that is, during the period November 25 through November 29, 2000 inclusive. This applies to all Medicare PPS beneficiaries, regardless of the original SOC. Subsequent follow-up assessments would be completed for these patients during the last 5 days of the next 60-day period, and so forth until discharge.	

OASIS CONSIDERATIONS FOR MEDICARE PPS PATIENTS

Type of Episode or Adjustment	OASIS Assessment: M0100 & M0825* Response Selection	Comments
1. PPS Start-up (cont'd.)	**All new patients after October 1, 2000:** All applicable (skilled care) patients (not just Medicare patients) accepted for care on or after October 1 will be assessed according to the new established time points at 42 CFR 484.55, i.e., a patient whose start of care date is October 15 would be re-assessed for the need to continue services for another certification period during the last 5 days of the current 60-day certification period. In this example, the follow-up assessment would be conducted during the period 12/9/00 through 12/13/00.	
2. a) First 60-day episode. b) New 60-day episode resulting from discharge with <u>all goals met</u> and return to same HHA during the 60-day episode. (PEP Adjustment) c) New 60-day episode resulting from transfer to HHA with no common ownership. (PEP Adjustment to original HHA)	Start of Care: (M0100) RFA 1 and (M0825) select 0-No or 1-Yes PEP Adjustment **does not** apply if patient transfers to HHA **with** common ownership during a 60-day episode. Receiving HHA completes OASIS on behalf of transferring HHA. Transferring HHA serves as the billing agent for the receiving HHA. Transferring HHA may continue to serve as the billing agent for receiving HHA or conduct a discharge assessment at end of episode. Receiving HHA starts new episode with Start of Care (if original HHA discharges at end of episode) (M0100) RFA 1 and (M0825) select 0-No or 1-Yes	

OASIS CONSIDERATIONS FOR MEDICARE PPS PATIENTS

Type of Episode or Adjustment	OASIS Assessment: M0100 & M0825* Response Selection	Comments
3. SCIC <u>with</u> intervening Hospital Stay during (but not at the end of) current episode.	Resumption of Care: (M0100) RFA 3 and (M0825) is 0-No or 1-Yes (or NA if no SCIC) Patient was transferred to the hospital and returns during the current episode. HHA completes the Resumption of Care assessment (RFA 3) within 48 hours of the patient's return, as required. ***The Resumption of Care assessment (RFA 3) also serves to determine the appropriate new case mix assignment for the SCIC adjustment***.	Recommend that for Medicare PPS patients, complete transfer **without discharge** assessment at the time of transfer.
4. SCIC with intervening Hospital Stay and return home during the last 5 days of an episode (days 56-60).	Resumption of Care: (M0100) RFA 3 and (M0825) is 0-No or 1-Yes **and** Follow-Up (M0100) RFA4 and (M0825) is 0-No or 1-Yes Patient was transferred to the hospital and returns home during the last 5 days of the current episode (days 56-60). HHA completes the Resumption of Care assessment (RFA 3) within 48 hours of the patient's return, as required. At (M0825) select 0-No or 1-Yes, based on therapy need for the <u>current</u> certification period. The Follow-up comprehensive assessment (RFA 4) is required during the last five days of the certification period. For payment purposes, this assessment serves to determine the case mix assignment for the subsequent 60-day period. A new Plan of Care is required for the subsequent 60-day episode.	For non-Medicare PPS patients, only a Resumption of Care assessment is necessary if the two time periods overlap. If no change in case-mix or HHA chooses not to claim a SCIC adjustment, only a ROC assessment is needed, as above. Remember that M0825 will be used to predict therapy need for the next 60 days and should be completed with this in mind.

OASIS CONSIDERATIONS FOR MEDICARE PPS PATIENTS

Type of Episode or Adjustment	OASIS Assessment: M0100 & M0825* Response Selection	Comments
4. SCIC with intervening Hospital Stay and return home during the last 5 days of an episode (days 56-60) (con't.)	***The Follow-up assessment (using RFA 4 and a 0 – No or 1 – Yes response to M0825) is required in addition to the Resumption of Care assessment if claiming a SCIC adjustment for the last few days of the current episode because the adjusted portion of the current episode and the new 60-day episode are subject to separate payment categories (HHRGs)***.	
5. SCIC <u>without</u> intervening Hospital Stay.	Other Follow-Up Assessment: (M0100) RFA 5 and (M0825) select 0-No or 1-Yes	
6. Subsequent 60-day episode due to the need for continuous home health care after an initial 60 day episode.	Recertification (Follow-up): (M0100) RFA 4 and (M0825) select 0-No or 1-Yes	
7. Patient's inpatient stay extends beyond the end of the current certification period. (Patient returns to agency after day 60 of the previous certification period.)	Start of Care: (M0100) RFA 1 and (M0825) select 0-No or 1-Yes When patient returns home, new orders and plan of care are necessary.	At time of transfer to inpatient facility, HHA completes transfer. If transferred without discharging, HHA will need to complete agency discharge paperwork (not OASIS data) before doing a new SOC. HHA starts new episode and completes a new start of care assessment when patient returns home.

*** (M0825) = NA is applicable for non-Medicare patients and Medicare patients where a SCIC adjustment is not indicated (for example, patient returns to home care from the hospital within the current episode and ROC indicates no change in current case mix.)**